

Springfield Insurance Enrollment Form – Medicare Retirees

List below all family members, including your spouse, who will be covered under your family plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for all children ends stage 196, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. You are required to complete a student or handicapped application for any dependent you are listing below who is age 19 or over. Attach separate sheet if additional space is required. Last Name First Middle Relationship Date of Birth Sex Social Security Number Reason for addition or deletion:	01 🔲										
Moders State First Moders Mod	Insured's GIC-ID (usually Soc. Sec. #)	Male .				De		Division #			
Note	Alterna Land	Female / /				•					
Health Select one of the health plans below and individual or family coverage) Health Select one of the health plans below and individual or family coverage) Health Select one of the health plans below and individual or family coverage) Health Select one of the health plans below and individual or family coverage) Health He	Name - Last		FIIət				IVII				
HEALTH COVERAGE Effective Date: 01/01/2007	Address			City			State	Zip Code			
Health Solicit one of the health plans below and individual or family coverage)					Home Phor	ne		Work Phone			
Health Solicit one of the health plans below and individual or family coverage)					()		()			
Health (Select one of the health plans below and individual or family coverage)	02 □ HEALTH COVERAGE							Effective	Date:	01/ 01 /2007	
Health Plan - Medicare Retirees	New Enrollment Decline Coverage										
Commonwealth Indemnity Plan Medicare Extension (OME) CIC: Yes No	□ Health (Select one of the health plans below and individual or family coverage)										
Fallon Senior Plan	Health Plan – Medicare Retirees										
Tufts Medicare Complement Tufts Medicare Preferred H enrolling in one of these five plans, complete the Plan's enrollment form and send it to the Plan SPOUSE/DEPENDENT INFORMATION List below all family members, including your spouse, who will be covered under your family plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for all children ends at age 19, except for full-time students and handcapped dependents whose applications have been approved by the Group Insurance Commission. Murried children are not eligible. You are required to complete a tudents and handcapped application for any dependent you are filting below who is age 19 or over. Attach state sheet if additional appeals required as a special part of the Group Insurance Commission. Murried children are not eligible. You are required to complete a tudents on the first Middle Relationship Date of Birth Sex Social Security Number. SPOUSE INFORMATION Reason for addition or deletion:											
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Reason for addition or deletion: SPOUSE INFORMATION Is your spouse employed? Ves No Name of employer Address of employer	SPOUSE/DEPENDENT INFORMATION List below all family members, including your spouse, who will be covered under your family plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for all children ends at age 19, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. You are required to complete a student or handicapped application for any dependent you are listing below who is age 19 or over. Attach separate sheet if additional space is required.										
SPOUSE INFORMATION Is your spouse employed? Yes No Name of employer Address of employer	Last Name First		Middle	Relationship		Date o	of Birth	Sex	Social Se	ecurity Number	
SPOUSE INFORMATION Is your spouse employed? Yes No Name of employer Address of employer Is your spouse covered under his or her employer's group health insurance plan? Yes No Name of insurance company Address No Children: Yes No If yes No Social Security Number Last First Middle Address Street City State Zip Code Is your former spouse employed? Yes No Name of employer Is your former spouse covered under his or her employer's group health insurance plan? Yes No Signature of Applicant Date Signature of Applicant Date Signature of Authorized Official Date Signature of Authorized Official							File as				
Is your spouse employed? Yes No Name of employer Address of employer Address of insurance company	Reason for addition or deletion:						ETTECTI	ve date:			
Policy/Certificate Number	SPOUSE INFORMATION Is your spouse employed? □ Yes □ No N	ame of employ	yer		_ Address	of employer					
Are you and/or your children covered under your spouse's group health insurance plan? You:			·			ame of insuranc	e company				
Name	Are you and/or your children covered under your spo	ouse's group he	ealth insurance plan?	You: ☐ Yes		Child	ren: 🗆 Yes	□No			
Last First Middle Address Street City State Zip Code Is your former spouse employed?	FORMER SPOUSE										
Street City State Zip Code Is your former spouse employed?	Name	Number	Date of Birth				Date of Divorce				
Street City State Zip Code Is your former spouse employed?		Middle									
Is your former spouse employed?			City				State		Zip Cod	le	
x Signature of Applicant Date Signature of Authorized Official Date											
To a large state of the state o	Is your former spouse covered under his or her empl	oyer's group h	ealth insurance plan?	□ Yes □ □	No						
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To a large state of the state o	X Signature of Applicant		Date	X	natura of /	Viithorizod Of	ficial		Doto		
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